

If your child needs a DENTIST please fill out and return this form for dental treatment at their school on the Friendly Dental Van.



Print School Name Here

Form with fields for First Name, Last Name, M.I., Address/P.O. Box, Birth Date, Child's Teacher, Grade in School, Child's Dentist of Record, and Child's Doctor's Name.

Please indicate if your child has Medicaid or NCHC and enter his/her MEMBER NUMBER below:

Form with checkboxes for Medicaid, NCHC, and a section for Recipient I.D. Number (with Letter).

If your child has dental insurance other than Medicaid or NCHC, please call our office for details.

For Information, Records or an Emergency - Phone 704-237-4202

Note: (1) If for any reason you need to obtain copies of your child's dental records, please call the above number. (2) You can give your child's medical history confidentially by mailing this form to our office or fax to 704-237-4263.

If there is a medical condition that requires pre-medication (including all diagnosed heart murmurs) please let us know. Medical questions must be answered before treatment. Please Check Correct Box on Each Medical History Question

Medical History section with checkboxes for Yes/No for various conditions like Heart Murmur, Asthma, Diabetes, Sickle-Cell Disease, Hepatitis, AIDS/HIV Virus, Tuberculosis, Rheumatic Fever, Mitral Valve Prolapse, Artificial Joints, Drug Allergies, and Currently Pregnant.

Please make a copy of this for your records, and make a note of the phone numbers for information or emergencies.

I hereby authorize the Friendly Dental Van Program to use or disclose any necessary patient health information (PHI) in order to carry out treatment, payment activities, and healthcare operations, as fully described in our Notice of Privacy Practices.

I am the parent or legal guardian of the above-named child and I hereby give the Friendly Dental Van Program and Dr. Gregory Abrams and/or his Associates permission to treat my child with cleaning, exam, X-rays, sealants, and fluoride treatment and, if cavities are found, to treat these.

Signature of Parent or Guardian: X

Please Print Parent or Guardian Name: X

If indicated, I give Dr. Gregory Abrams and/or his Associates permission to perform dental extractions. Yes [ ] No [ ]